GEORGIA STATE BOARD OF WORKERS' COMPENSATION
INDIVIDUALIZED REHABILITATION PLAN

Board Use Only	
Reviewer	
Date	Status

____
County of Injury

SECTION I. IDENTIFYING INFORMATION

1. ______________________ Employee Name
2. ______________________ Social Security Number
3. ______________________ Date of Injury
4. ______________________ Occupation
5. ______________________ Date of Birth
6. ❑ No Yes ❑ Catastrophic Injury
7. Diagnosis & Functional Restrictions ______________________

____

SECTION II. PLAN INFORMATION (Please check the appropriate blocks)

TYPE OF PLAN

_____ MEDICAL CARE COORDINATION (Catastrophic Cases Only)
_____ INDEPENDENT LIVING
_____ EXTENDED EVALUATION

_____ VOCATIONAL SERVICES (Select One)
❑ RTW/SAME EMPLOYER
❑ JOB MODIFICATION
❑ GRADUATED
❑ PLACEMENT
❑ ON-THE-JOB TRAINING
❑ FORMAL TRAINING
❑ SELF EMPLOYMENT

THE FOLLOWING DOCUMENTATION IS SUBMITTED FOR PLAN APPROVAL

_____ INITIAL REHABILITATION REPORT
_____ RELEASE TO RTW
_____ PHYSICAL RESTRICTIONS
_____ PHYSICAL CAPACITIES
_____ PAIN/PSYCHOLOGICAL REPORTS
_____ REHABILITATION NARRATIVE REPORT
_____ PHYSICIAN'S APPROVAL OF JOB

_____ JOB ANALYSIS AT TIME OF INJURY
_____ ANALYSIS OF OFFERED JOB
_____ TRANSFERABLE SKILLS ANALYSIS
_____ VOCATIONAL EVALUATION
_____ SUMMARY OF LABOR MARKET SURVEY
_____ MEDICAL NARRATIVE REPORTS
_____ OTHER

GIVE A STATEMENT (INDIVIDUALIZED TO THIS CASE) AS TO WHY SERVICES OF A REHABILITATION SUPPLIER ARE NEEDED

____

____

____

COMPLETE THIS INFORMATION FOR AN AMENDED PLAN

Type of Original Plan ______________________ Date of Original Plan ____________

Type of Previous Amended Plan ______________________ Date ____________

If services were interrupted in the Original/Amended Plan, state reason ______________________

____

If services are to be a continuation of a Previous Plan, state the need and justification for continuation ______________________

____

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G .A. §34-9-18 and §34-9-19).

SECTION III COMPLETE THIS PART FOR THE CHECKED TYPE OF PLAN

________ MEDICAL CARE COORDINATION (Catastrophic Cases Only) _______ INDEPENDENT LIVING ______ EXTENDED EVALUATION

STATE SPECIFIC PROBLEMS

STATE SPECIFIC GOALS

SECTION IV. COMPLETE THIS PART FOR CHECKED VOCATIONAL SERVICES

1. ____ JOB MODIFICATION ____ GRADUATED ____ RTW ____ PLACEMENT ____ OJT ____ FORMAL TRAINING

STATE REASONS FOR TYPE OF PLAN SELECTED

2. COMPLETE WORK AND WAGE INFORMATION:

AVG WEEKLY WAGE AT TIME OF INJURY $ _______ OR PER HOUR ________ ANTICIPATED WAGES $ _______ PER WEEK

WAGE LOSS $ ________________ HOURS WORKED PER WEEK AT TIME OF INJURY ______________

PROPOSED FULL TIME WORK ______________ OR PART TIME WORK ____________________

3. OCCUPATIONAL OBJECTIVES

4. EDUCATIONAL/VOCATIONAL BACKGROUND

5. OCCUPATIONAL OBJECTIVES DETERMINED BY:

__________ TRANSFERABLE SKILLS Date __________ Determined by ________________

__________ VOCATIONAL EVALUATION Date __________ Evaluator ________________

SUMMARY OF VOCATIONAL EVALUATION

6. SUMMARY OF LABOR MARKET SURVEY (ATTACH REPORT) DATE COMPLETED __________

SS# ________________

SECTION V. Services and Responsibilities Required to Meet Goals (Attach additional pages as needed)	Initiation Date	Projected Completion Date	Estimated Cost	Payer
Proposed Cost of Plan			$ ____________	

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SS# ______________________

SECTION VI. CERTIFICATE OF SERVICE (THIS SECTION MUST BE COMPLETED BY THE PRINCIPAL SUPPLIER)

I CERTIFY THAT I HAVE DISCUSSED THIS PLAN WITH THE EMPLOYEE AND OTHER PARTIES TO THE CASE AND HAVE MAILED COPIES ON ______________ TO THE FOLLOWING PARTIES AT THE CURRENT ADDRESSES BELOW.
DATE

Employee Address ______________________ Telephone ______________

Employer Address ______________________ Telephone ______________

Insurance Adjuster Address ______________________ Telephone ______________

Employee's Attorney Address ______________________ Telephone ______________

Employer's Attorney Address ______________________ Telephone ______________

Subsequent Injury Trust Fund Address ______________________ Telephone ______________

SIGNATURE ______________________ Registration No. ______________
Rehabilitation Supplier ______________________ Expiration Date: ______________
Address ______________________ Telephone ______________
Catastrophic Intern (If Any) ______________________ Registration No. ______________
Expiration Date: ______________

EMPLOYEE COMMENTS ABOUT THIS PLAN: ______________________

DATE __________ EMPLOYEE'S SIGNATURE ______________________
This indicates that you have read or have had read to you the plan, not that you agree with the plan.

DO ALL PARTIES AGREE TO THIS PLAN? (   ) YES   (   ) NO

Is this case applicable for Kid's Chance scholarships? (   ) YES   (   ) NO
If yes, submit application to Kid's Chance, Inc.

SECTION VII. APPROVAL/OBJECTIONS, FIFTEEN (15) DAY NOTICE

ABSENT WRITTEN OBJECTIONS WITHIN 15 DAYS OF THE DATE MAILED, THE REHABILITATION REQUEST IS APPROVED EFFECTIVE THE DATE OF THE CERTIFICATE OF SERVICE. NO FURTHER CORRESPONDENCE WILL BE ISSUED BY THE BOARD.
IF THERE IS AN OBJECTION:

(1) THE OBJECTION MUST BE IN WRITING.
(2) IT MUST BE RECEIVED BY THE GEORGIA STATE BOARD OF WORKERS' COMPENSATION WITHIN 15 DAYS OF THE DATE OF THE CERTIFICATE OF SERVICE.
(3) A CERTIFICATE OF SERVICE MUST BE COMPLETED STATING THAT COPIES OF THE WRITTEN OBJECTIONS WERE PLACED IN THE MAIL TO ALL PARTIES AND THE PRINCIPAL REHABILITATION SUPPLIER THE SAME DATE AS THE CERTIFICATE OF SERVICE

ANY OBJECTIONS RECEIVED BY THE BOARD WILL BE PROCESSED IN ACCORDANCE WITH O.C.G.A. §9-11-6 (e).